



APPLICATION FOR CONSTRUCTION PERMIT FOR ACUTE CARE FACILITIES

State Form 50097 (R/5-05)
Approved by State Board of Accounts, 2005
Indiana State Department of Health
Sanitary Engineering

DATE RECEIVED _____

RECEIPT NUMBER _____

- INSTRUCTIONS: 1. Send check or money order along with plans to:
Indiana State Department of Health
Attention: Cashier's Office
P.O. Box 7236
Indianapolis, IN 46207-7236
2. Direct questions to: 317-233-7177

**FAXED COPIES OF APPLICATIONS
WILL NOT BE ACCEPTED**

<p>1. OWNER _____ Name _____ Address _____ Phone No. _____</p>	<p>5. The Following Documents are Attached: (CHECK WHERE APPLICABLE)</p> <p>A. Water Supply: <input type="checkbox"/>Public <input type="checkbox"/>Existing <input type="checkbox"/>Private <input type="checkbox"/>New</p> <p>B. Plot Plan with Site Utilities <input type="checkbox"/></p> <p>C. Sewage Disposal: <input type="checkbox"/>Public <input type="checkbox"/> Existing <input type="checkbox"/>Private <input type="checkbox"/> New</p> <p>D. Plans and Specifications certified by Architect or Engineer: <input type="checkbox"/></p> <p>E. License of Facility (1) Hospital <input type="checkbox"/> (2) Ambulatory Outpatient Surgical Center <input type="checkbox"/></p> <p>F. Life Safety Code Analysis Certified by Architect or Engineer <input type="checkbox"/></p> <p>G. Fees Required by 410 IAC 6-12-17 <input type="checkbox"/> (see other side)</p> <p>H. Estimated costs of construction <input type="checkbox"/> (see other side)</p> <p>I. Public Notice under IC16-21-2-11.5 <input type="checkbox"/> (see other side)</p>
<p>2. OWNER'S DESIGNATED AGENT Name _____ Title _____ Address _____ Phone No. _____</p>	
<p>3. FACILITY (TYPE OF PROJECT:) _____ Name _____ Address _____ _____ City _____ County _____ ZIP _____</p>	
<p>4. ENGINEER/ARCHITECT Name _____ _____ Address _____ _____ Phone No. _____ License # _____ Signature _____</p>	<p>6. SIGNATURE Application is hereby made for a Permit to authorize the activities described herein. I certify that I am familiar with the information contained in this application, and to the best of my knowledge and belief such information Is true, complete, and accurate.</p> <p>_____ Printed Name of Person Signing</p> <p>_____ Title</p> <p>_____ Signature of Owner or Designated Agent</p> <p>_____ Date of Application Signed</p>

INSTRUCTIONS FOR COMPLETION OF CONSTRUCTION PERMIT FOR ACUTE CARE FACILITIES

1. Owner
Name and address of person, company, firm, municipality, authority, etc.,
2. Authorized Agent
Name, title, address, and phone number of person who is designated to act for owner and who is familiar with the project and can furnish additional information as required.
3. Name of Facility or Project
State its name, location, and nearest possible address.
4. Name of Engineer/Architect
Name, title, company, address and phone number of engineer or architect registered in the State of Indiana who certified and sealed the construction plans and specifications. **Registration number and signature must be provided.**
5. Check the Squares Indicating Name of Documents Attached to Application.
All Documents are Required Except Where Inapplicable
 - A. Specify the type of water supply serving the subject facility, and whether new or existing.
 - B. Plot plan or plans to scale showing property lines, structures, roads, and site utilities.
 - C. Specify the type of sewage disposal serving the subject facility, and whether new or existing
 - D. A description of services within this facility; x-ray calculations prepared by a registered physicist; and detailed architectural plans including site utilities, mechanical and electrical prepared by an Indiana registered architect or engineer
 - E. Specify the type of licensed facility
 - F. Hospitals and AOSC must comply with the Life Safety Code, NFPA 101, 2000 edition certified by an Indiana registered architect or engineer. Attach analysis.
 - G. **Fees Required by Rule 410 IAC 6-12-17.**

Ambulatory Outpatient Surgery Center	\$450
New Hospital or Hospital Addition	\$550
Remodeling of existing hospital	\$300
 - H. Provide estimated costs of construction not including equipment installation or consulting fees.
 - I. **Public Notification required** under IC16-21-2-11.5

If Ambulatory Outpatient Surgery Center construction costs not including equipment or consultants exceeds \$3,000,000, or if Hospital construction costs not including equipment or consultants exceeds \$10,000,000, then provide a copy of each of the two published public notices, dates published and name of publication(s) and in what city(s) or town(s).
6. Signature
An application submitted by a corporation must be signed by a principal executive officer of at least vice president level or his duly authorized representative, if such a representative is responsible for the overall operation at the facility from which the construction described in the form will originate. In the case of a partnership or a sole proprietorship, the application must be signed by a general partner or the proprietor, respectively.

